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ABSTRACT

Substance abuse is a family disease, which can be transmitted both genetically and by the family environment. Legal and illegal use of alcohol, tobacco, and other drugs (ATOD) can affect children through a number of avenues. In planning for allocation of Proposition 10 funds, the use, abuse, and dependence on ATOD by parents, siblings, relatives, and caretakers raises issues in all three of the primary areas of concern of Proposition 10 funding: 1) Parent Education and Support Services; 2) Child Care and Early Education; and 3) Health and Wellness. This paper proposes that Proposition 10 commissions reviewing their options should bear in mind that both short-term expenditures and longer-range investments can help address the problems of younger children affected by ATOD. In the short range, the biggest data gaps need to be filled so that commissions can have a better idea of which children and parents they are targeting. Longer-term priorities could include ensuring that investments in home visiting and other early intervention efforts include adequate emphasis upon ATOD problems, both in identification of ATOD-related effects and in parent education and support. Longer-term investments should also seek to build the capacity to shift resources over time from less effective to more effective programs, and to move from measuring programs' outputs to measuring their outcomes on parents and younger children. Three appendixes contain a literature review and organizational contacts; relevant California experts by county; and options for the use of Prop 10 funds. (GCP)

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Building Community Systems for Young Children

Building Community Systems for Young Children is a series of reports designed to support the implementation of Proposition 10: The California Children and Families Act. Each installment is written by a team of experts and provides comprehensive and authoritative information on critical issues concerning young children and families in California.

June 2000

Alcohol, Tobacco and Other Drugs in the Lives of Young Children

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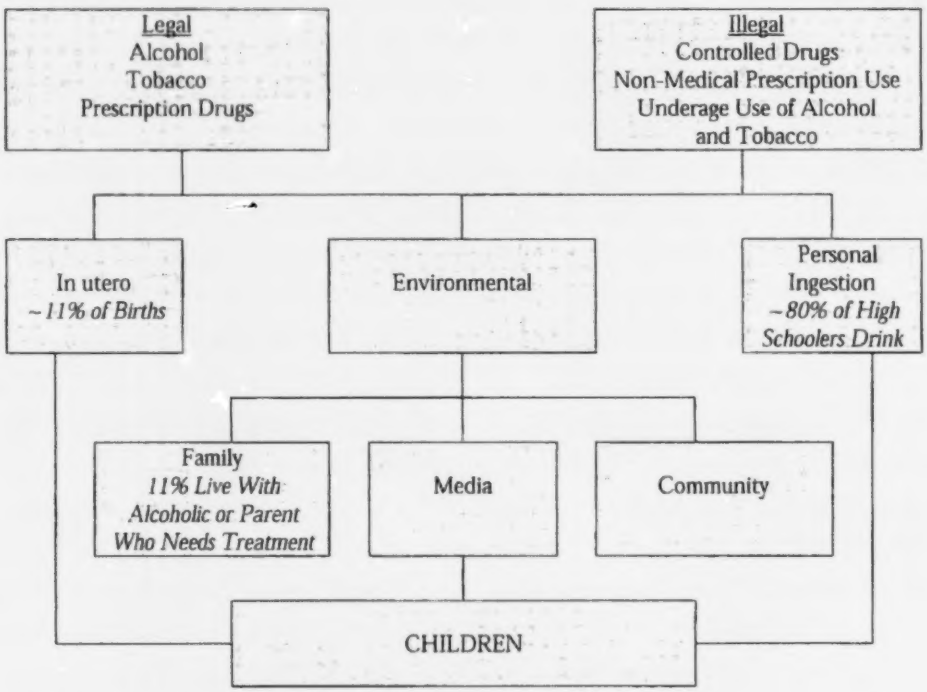
Alcohol, Tobacco, and Other Drugs in the Lives of Young Children

I. Introduction

Substance abuse is a family disease, which can be transmitted both genetically and by the family environment. Younger children in families are affected by substance abuse in several ways, as illustrated by the following chart:

Chart 1: How Are Children Exposed to Alcohol, Tobacco, and Other Drugs?[1]



Legal and illegal use of alcohol, tobacco, and other drugs (ATOD) can affect children through a number of avenues, which include but are not limited to prenatal exposure *in utero*. This has very powerful policy implications, including the message that prenatal drug exposure, while very important in its effects on younger children, *is only one of the several ways that younger children can be affected by ATOD.* Children are also exposed to ATOD through their parents 'and caretakers 'use and abuse, through commercial media messages advertising alcohol and tobacco, and community norms and regulations regarding ATOD use. The legality of the substance and the nature of a child ś exposure to it play a significant role in its effect on the child.

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It is commonly known that prenatal exposure to ATOD can have a lasting effect on children's health and well-being. However, *postnatal* exposure can also affect children in lasting ways. Children who fail to form secure attachments to their caregivers because of their parents' inability to give them sustained attention; children who come home from school to a home where violence and substance abuse are frequent; children who grow up in neighborhoods where there are ten times as many liquor outlets and ads as in the rest of the community; adolescents who receive daily messages that to use alcohol is to be surrounded by attractive people having fun— all of these are effects of ATOD on children in the settings of their family and community. In its recent Report to Congress, the federal Department of Health and Human Services cited data showing that 11% of all children in the nation live with a parent who is either alcoholic or in need of treatment for their abuse of illicit drugs. The Report says that

> Children prenatally exposed to drugs and alcohol represent only a small proportion of the children affected and potentially endangered by parental substance abuse.[2]

When county commissions examine the extent of need in the community for attention to ATOD issues, it will be important for them not to focus only on the known and most identifiable cases— the children and families who are currently receiving some type of services or who have been diagnosed as needing such services. As important as these higher-needs children and families are, commissions should weigh their needs against a larger segment of the population with needs for ATOD-related services: those children and families using legal and illegal drugs with negative effects which are not yet easily observable. A much larger number of children are exposed to milder ATOD effects than those exposed to extreme effects, and Proposition 10 decision-making will need to assess the benefits of services to each of these groups. The question is whether measurable results will be more readily achieved by targeting severe- or milder-risk cases, and for how many children. The criteria used by Proposition 10 commissions in setting priorities among the many programs they could fund should take into account the range of severity of need among younger children. It may be more appropriate to think of treatment funds being allocated to the children and families with the greatest need, early intervention funding being allocated to those that are at risk, and prevention funds being allocated to a much wider group of children whose needs are not as severe.

In planning for allocation of Proposition 10 funds, the use, abuse, and dependence on ATOD by parents, siblings, relatives, and caretakers raises issues in all three of the primary areas of concern of Proposition 10 funding: 1) Parent Education and Support Services; 2) Child Care and Early Education; and 3) Health and Wellness.

Parent education is relevant to ATOD abuse because choices about which parents to include and what they need to know both raise issues of substance abuse: How can family support programs deal with substance abuse issues when this may raise difficult issues for parents who are voluntary participants in those programs? *Child care and early education* are related to

substance abuse in several ways, including problems with the cognitive and social/behavioral development of some substance-exposed children, and the potential for early care programs with active parent involvement to identify and address substance abuse problems. *Health and wellness* have obvious connections with substance abuse as it affects the physical and mental health and mental health of young children.

Six steps in planning responses to ATOD use and abuse

Thinking strategically about the effects of substance abuse on younger children requires that Proposition 10 commissions take six key steps:

1. Assemble the best available data in the county on the numbers of children and families affected by the major categories of ATOD effects: developmental delays resulting from prenatal ATOD exposure, reports of child abuse and neglect caused by parental substance abuse, health conditions caused or worsened by substance abuse, and foster care and adoption services for children affected by ATOD.

2. Review current methods of identifying children affected by ATOD, including testing at birth, pediatric examinations, developmental assessments, pre-school testing, and reported child abuse and neglect.

3. Review the need for programs that respond to the above conditions with efforts aimed at both parents and their children, including prevention, early intervention, and treatment, recognizing that as different programs choose to emphasize different points along a spectrum from prevention to treatment, the numbers of children decrease (with more needing prevention and fewer needing treatment), while the costs of effective programs tend to increase.

4. Collect information on effective model programs both within the county and in other counties and states.

5. Determine what successful outcomes have been achieved by current programs operating in the county and whether their operators are able to measure their effectiveness or are willing to establish results-based funding agreements using Proposition 10 funds.

6. Determine the extent of impact of alcohol and other drug (AOD)* problems on the critical subset of infants and young children in the child welfare systems who are at risk of being removed from their homes or who already have been removed.

The issue of detecting prenatal exposure

As stated in the State Commission guidelines for Proposition 10 strategic planning,

> Prenatal exposure to tobacco, alcohol, and illicit drugs increases a child's risk of mental retardation, neurodevelopmental deficits, attention deficit disorders with hyperactivity, fine-motor impairment, as well as more subtle delays in motor performance and speech. Maternal smoking and infant exposure to environmental tobacco smoke has been linked to asthma, low birth weight and an increased risk of sudden infant death syndrome.

It is important to recognize, however, that only a small proportion of the children who are in fact prenatally exposed to ATOD are actually identified as exposed. This is due to three major factors: (1) drug screening is not done uniformly in all hospitals; (2) drug screening at birth detects only a portion of those children who were prenatally exposed - only those whose mothers used the substance within 2 to 3 days before delivery; and (3) screening does not test at all for alcohol or tobacco, both of which can have severe prenatal effects.

Drug testing of urine at birth is not performed on all infants, and even if it were, it would not detect use prior to the few days before birth. This under-detection of substance use during pregnancy is documented by the large gap between current levels of *reported* drug-exposed births at the county level and estimates of the percentage of such births based on a statewide study performed in California hospitals in 1992. This study found that an average of 5.2% of all births involved detectable exposure to *illicit* drugs, while in most counties the current level of reporting gives reports of fewer than 1% of all births as drug-exposed. The authors of this *New England Journal of Medicine* study concluded: "[W]e estimate that 11.35% of maternity patients at California hospitals in 1992 (approximately 67,000 women) had used a licit or illicit drug, or alcohol, within hours or days of delivery. "[8] National surveys have also estimated that each year, 11% of all newborns are exposed to illicit drugs.[4]

> *Planning tip*
> *Planners can look for a gap between reported drug-exposed births in their county and the projected number based on the 1992 California study. Such a gap may suggest that hospitals are not fully reporting or detecting drug-exposed births.*

* The authors use AOD to indicate alcohol and other drugs and ATOD to indicate alcohol, tobacco and other drugs. Tobacco is added when, as in the case of Proposition 10, tobacco prevention is a specific activity that is targeted by the funding.

However, this figure greatly understates the extent and therefore the impact of ATOD exposure because it measures only drug use within the last few days before birth and it ignores entirely the harmful effects of prenatal use of tobacco. In some California counties, studies document that as many as 14% of all births involve detectable use of alcohol or other drugs.[5] It should also be noted that women who do have positive toxicology screens and are using cocaine are often those with severe use patterns and actually have more severely affected children as measured by higher rates of low birthweights, small head circumferences, and other risk factors.

There are numerous challenges inherent in clearly identifying substance-exposed infants. Some physicians and hospitals are reluctant to identify children as having substance exposure problems. Pregnant women may also be reluctant to seek treatment for their substance abuse problems during pregnancy out of concern that they may lose custody of their children.

It must be emphasized, however, that the most important forms of substance abuse during pregnancy are the use of alcohol and tobacco, rather than illegal drugs.[6] Recent surveys indicate that 12-14% of pregnant women consume alcohol. Two-thirds of female smokers continue to smoke during pregnancy. These *legal* drugs are potentially more serious in their prenatal impact than those detected by toxicological tests at birth, both in the total number of children affected as well as the more serious documented problems of central nervous system impairments due to alcohol exposure and babies who are small for their gestational age due to maternal smoking. This suggests strongly that a much larger number of children are prenatally exposed to these harmful but legal drugs than are exposed to cocaine, marijuana, or other illegal drugs.

Above all, it should be recognized that detection of prenatal exposure is only the first step in responding to the prenatal effects of ATOD on children; it is the response to that identification with needed services and treatment that represents a serious policy intervention, not just the effort to identify these children.

The special case of tobacco

Prenatal and early exposure to tobacco has special consequences for younger children, as noted in the State Commission guidelines materials:

> Maternal smoking and infant exposure to environmental tobacco smoke has been linked to asthma, low birth weight and an increased risk of sudden infant death syndrome.... The health effects on the fetus are profound, if a mother smokes or is exposed to second-hand or environmental tobacco smoke (ETS) during pregnancy. Research has shown that when a pregnant woman smokes or is exposed to tobacco smoke, the supply of oxygen and nutrients circulated to the fetus is adversely affected and has an injurious effect on the baby's development and survival.

The risks continue in early years:

> Exposure of young children to second-hand or environmental tobacco smoke on young children has a devastating effect. It has been shown that children in households with parent(s) who smoke are more susceptible than children in non-smoking households to suffer from respiratory illnesses and infections such as bronchitis and pneumonia, reduced lung function, chronic middle ear infections, and increased frequency and severity of symptoms in asthmatic children.

Responses to ATOD use and abuse: Broad strategies

For all the importance of these prenatal effects, again it should be emphasized that family and community impacts on younger children also play an important role in child well-being, in this case increasing their risks of becoming substance abusers themselves. The costs associated with family and community exposure to ATOD justify a response from Proposition 10 commissions.

In deciding how to respond to the problems caused for younger children by parental ATOD use and abuse, Prop 10 commissions should weigh five broad strategies:

1. Better identification of exposure and risk, targeted to both parents and children.

2. Prevention efforts designed to reduce or eliminate use of ATOD by pregnant and parenting mothers and fathers.

3. Prevention efforts aimed at broader public education of the harmful effects of ATOD exposure on the very large group of children who have not come to the attention of service providers.

4. Intervention aimed at both parents and children— programs that respond to an identified problem with parental AOD treatment and interventions specific to the child, based on developmentally appropriate efforts, including interventions for younger children that are linked to preschool initiatives, home visiting, and other parent support programs.

5. Support for children who have been removed from their families and placed in out-of-home care or kinship care because of a drug-exposed birth, detection of problems with the child's safety, or the failure of parents to comply with substance abuse treatment or other court-ordered services. Such support often includes aid to foster and adoptive parents in ensuring that the child's environment is positive and nurturing and addresses any deficits that may have resulted from prenatal and postnatal ATOD use and abuse by birth parents.

While all of these should be pursued, commissions will want to examine what mixture of these approaches best fits the needs and resources in their communities.

II. What We Know About What Works

A number of successful programs have responded successfully to the needs of younger children with exposed to ATOD. These include programs in all five categories listed above.

Many sources point out that *whole-family* measures are better than programs that separately address the problems of children or the problems of their parents. Whole-family, two-generation programs are at times more difficult to plan and implement, and they can be more expensive as well. But the evidence of their greater effectiveness is growing.[7] Hundreds of two-generation projects now exist across the nation, serving thousands of families, according to a 1995 assessment of two-generation programs, which also found that programs with more intensive services and longer participation rates showed better outcomes than those that had fewer services for shorter periods of time.[8] It should also be emphasized that none of the models evaluated included a major emphasis upon parents 'drug and alcohol use and its effects upon their children.

A Model of Best Practice

SHIELDS For Families is a comprehensive program based in South Central Los Angeles. SHIELDS seeks to decrease the prevalence of substance abuse, child abuse and neglect in South Central/Compton, increase the number of drug/alcohol-abusing women seeking prenatal care and treatment, and promote family reunification and support families remaining intact in the community. Since SHIELDS began its services, the number of infants born drug-exposed at Martin Luther King Hospital was drastically reduced, from 1200 annually in 1989 to 250 annually in 1995.

Many of the most promising programs also work *across* agencies, rather than within them. A program run by a single agency may lack connections to other agencies whose support is critical to program success.

A further lesson of successful programs is that they are clearly focused upon the front lines of services to children and families— the points in the current system where younger children are most likely to be seen by professionals and others able to detect needs caused by ATOD problems. Such face-to-face front-line contact can be in WIC programs, pediatricians 'offices, obstetricians ' offices, family planning clinics, and through other providers who have frequent contact with women in their child-bearing years who might be using alcohol, tobacco and other drugs. These professionals need to be linked effectively to ATOD services by training them to watch for the effects of ATOD problems and assuring them that there will be an appropriate response by these service providers when ATOD problems are diagnosed.

Ingredients in programs that work

Several of the critical ingredients in successful programs, based on the experience of programs funded by the Center for Substance Abuse Treatment and California ś Options for Recovery program, include an emphasis on:

- providing services to the whole family;
- engaging clients repeatedly, since clients who stayed in treatment longest had the best outcomes;
- non-ATOD services to women who have multiple problems in addition to their addiction, including job services, mental health counseling, and health services;
- building child development services into treatment programs; and
- including after-care and follow-up services as a part of treatment.

A consistent indicator of successful substance abuse treatment outcomes is the length of time the patient stays in care. Although appropriate duration depends on the individual ś specific problems, for most patients the threshold for significant improvement is reached at about 3 months in treatment. Additional treatment can produce further progress toward long-term recovery.

A Model of Best Practice

PROTOTYPES is a Los Angeles County-based agency that provides substance abuse and mental health treatment and domestic violence services to women and child care services for their children. PROTOTYPES outreach workers recruit women from different community sites who are in need of treatment. They have developed strong relationships with the local Child Protective Agency offices. For PROTOTYPES, keeping clients has been more of a challenge than getting clients. The strategies that have given PROTOTYPES positive results include encouraging clients to: find a peer to bond with, find a staff person to bond with, openly acknowledge that entering a structured treatment environment is very difficult, and identify the Women's Center as home.

Parent education: issues to watch out for

A frequent response to the needs of parents is some form of parent education. Some communities have several programs that provide support to parents; one Southern California community of 300,000 recently counted 63 separate parent education programs within its boundaries.

But such programs often exclude in-depth discussion of substance abuse and its effects on younger children. At times this can be because an orientation to a "strengths-based curriculum" means that a family ś problems with ATOD may not be addressed for fear that emphasis on the family ś deficits would result in families being reluctant to enter the program. In addition, when substance abuse issues are discussed in parent education programs, the focus is most often placed on preventing pre-adolescent and adolescent use and abuse of ATOD, rather than impacts on younger children. A major exception to this tendency is the Starting Early, Starting Smart

program highlighted in the box to the right. Its model of integrated child development services and substance abuse prevention is based on recognition of the need for links between these two types of programs.

Proposition 10 planning groups should also review the curricula and training for home visiting programs to determine whether the content and worker preparation adequately address ATOD issues.

A Model of Best Practice

Starting Early, Starting Smart is a federally-funded project with Annie E. Casey Foundation support that has funded 12 sites which are integrating early childhood and substance abuse prevention efforts aimed at parents and their children. http://www.samhsa.gov/grant/primarycare/0709pagetwo.htm

Pediatricians and HMOs: Key intervention points

A potential strategy for improving community responses to the ATOD problems of younger children are educational efforts aimed at pediatricians and health maintenance organizations (HMOs,) who do not always detect ATOD problems or include them in regular health screenings. These health service providers do not always recognize maternal depression, accidents in the home or automobiles, and respiratory problems as potential signs of ATOD use and abuse. Special training in recognizing and responding to ATOD problems is available from national organizations such as the American Academy of Pediatricians and the National Association of Children of Alcoholics (NACOA). NACOA has developed standards and competencies for health professionals which would be helpful in working with pediatricians, nurses, and others who see parents of younger children regularly but who may not detect ATOD problems or know how to refer patients to early intervention and treatment agencies or how public funding for such services can be provided.

Another intervention point is the approach taken by managed care organizations (MCOs) in screening for and covering ATOD-related conditions. County commissions could review these practices by MCOs and clinics that regularly see parents of younger children and highlight the best practices of MCOs and clinics that are most responsive to ATOD problems. Special emphasis should be given to reviewing the practices of managed care organizations with substantial numbers of Medi-Cal clients.

III. Integrating and Coordinating Systems and Programs

In reviewing existing programs for younger children affected by ATOD use, Proposition 10 planners should work from the best available inventory of such services to identify possible gaps and overlap in those services. This effort to "map the system" is essential to understanding who now provides ATOD-related services to younger children and their parents. The inventory should also identify funding sources to determine what revenues are used in these programs, as a means of assessing whether Proposition 10 funds could be used to leverage these existing funds, rather than using Proposition 10 funds without any matching.

This map of the current system will approach programs for younger children from two different perspectives— asking early childhood programs how they address ATOD issues, and asking ATOD programs how they address the problems of younger children. In most cases, the "system" will consist of a few pilot projects and smaller programs that may be doing a good job for a small percentage of the children and parents who need such services. But a few pilot projects do not make a system. In fact, in some recent literature about innovation in services to children and families, notably Lisbeth Schorr's *Common Purpose*, it is argued that pilot projects are at times how systems insulate themselves from change.

Three specific questions that might be asked of operators of current programs in building an inventory of existing services are:

1. How does the program identify ATOD-affected parents and younger children among its clients - what risk factors are used: drug-exposed births, families with prior drug-exposed babies DEBs or child abuse and neglect, or other factors?
2. How does the program define and measure success for its clients in both short-term and long-term outcomes?
3. How do these programs collect information about their ATOD-affected clients to determine whether they are making progress toward recovery and improved parenting?

It is likely that planners will find that some programs do an excellent job of compiling data that can be used to evaluate programs' success, while others may operate in a pre-accountability mode in which the primary data collected is counting clients and units of service, rather than outcomes and indicators of the effectiveness of such services. That is the critical importance of the second question about defining success, for only those programs with experience with such outcomes can assure effective and efficient use of Proposition 10 funding.

If Proposition 10 funds are to be used as "glue" across existing programs, rather than for setting up new, fragmented and unconnected services, the primary strategy must be to develop *shared outcomes across service providers*. This is a critical task that is at the heart of Proposition 10 planning and implementation. Achieving this cannot be done in a single meeting; it requires a commitment to understanding other agencies' goals and objectives, what their funders mandate as measures of effectiveness, and how clients served by different agencies may overlap in different caseloads, such as welfare, child welfare, and treatment agencies.

Once agencies have developed shared outcomes, there will be a need for a community-wide "score card" of the key indicators for reducing the harmful effects of ATOD use on younger children. Through such a score card of indicators and an annual summary of progress made against baselines, the community as a whole can determine annually whether agencies' efforts add up to real change. Such indicators might include:

1. The number of drug-exposed children (recalling, however, that this data is flawed to start with in most communities because of under-reporting)
2. The number or percentage of at-risk parents with younger children enrolled in or successfully completing parent education with ATOD components
3. The number of parents using legal or illegal drugs during pregnancy
4. The number of parents with ATOD abuse enrolled in and successfully completing treatment
5. The number of infants removed from their parents and placed in foster care due to substance abuse. The total number in foster care by county is available at http://www.childrennow.org/california/RC99/databook-99.pdf. The number of younger children removed because of substance abuse was estimated in a 1998 General Accounting Office (GAO) report to be 78%, but this percentage should be verified by each county.

In developing a consensus on what indicators should go into a score card for measuring progress in reducing ATOD harm to younger children, planners should seek to involve as wide a cross-section of parents (those at risk and others), service providers, educational institutions, and other stakeholders in setting priorities. The indicators should not be developed by a small group of planners working by themselves, but in the most inclusive process possible, with an opportunity for a wide group to review and revise the indicators annually as more data becomes available.

Once a score card is developed, the issues that arise next are how to provide oversight and governance for program activities aimed at ATOD abuse affecting younger children. Several models have emerged, some from communities 'experience with early childhood coalitions and some from community-level work with ATOD prevention and treatment coalitions. A third body of work which is also relevant to the question of governance is the work in the child welfare field that has sought deeper community involvement in responding to the causes and symptoms of child abuse. Courts are also critical players in providing services to younger children in the child welfare system. Each of these will be briefly reviewed.

Early childhood coalitions such as Success by Six or Ready at Five groups in cities and states have defined outcomes for school-readiness and early childhood development in many communities. Usually these groups do not focus upon ATOD issues, but those groups working on maternal and child health in such coalitions have at times addressed ATOD issues in prenatal care. Proposition 10 planners should review the work of such groups in their communities to see how much attention has been given to ATOD issues on their agendas.

In ATOD prevention coalitions, adolescent and adult use have usually been the major focus, but prenatal exposure and drug-exposed births have at times become a focus of ATOD prevention and treatment programs. Where a strong perinatal coalition exists, as it does in

several California counties, there is a strong base for this work. Such coalitions are important resources in planning county-wide efforts, particularly for after-care programs and public education efforts aimed at parents of younger children.

Other agencies with important roles in responding to substance abuse effects on younger children include regional centers and other developmental disabilities agencies that screen for and respond to developmental problems in younger children; Medicaid, which provides services to lower-income pregnant and parenting mothers; special education units in school districts which handle children with disabilities as they enter school; and child care and pre-school providers, including Head Start, some of which work with parents to prevent substance abuse and provide parent education on its effects.

The third set of groups that may have some relevant experience in coalition building are child abuse coalitions that have recognized explicitly that ATOD use has a direct link with child abuse and neglect. Surprisingly, many coalitions working on child abuse have not seen ATOD issues as being in their bailiwick, despite the extensive evidence of correlations between substance abuse and child abuse. Proposition 10 planners should review these groups' experience with ATOD issues in determining what role they might have in supporting new or expanded programs that address this problem.

A final set of groups that should be added to the coalition-building mix are the domestic violence coalitions that exist in many counties. These coalitions include professionals and volunteers who are very knowledgeable about the high correlation of family violence and AOD abuse. Family shelters are also a vital part of the broad coalition addressing AOD problems, since many of the parents entering shelters have younger children. Services to these children, who have often been exposed to AOD abuse as well as violence, are often inadequate.

The CPS connection

An especially important connection to make in serving younger children at risk of harm due to ATOD is the link between child protection agencies (CPS) and drug and alcohol treatment agencies. This connection is critical because protective service agencies, which handle child abuse and neglect cases, estimate that at least 60% of all cases entering the child welfare system involve drugs or alcohol. In most California counties, these agencies operate in completely separate parts of county government, with few opportunities to develop a common agenda and shared measures of effectiveness. However, since 1997, a group of leaders of both child welfare and AOD treatment agencies from several counties has been meeting jointly under the auspices of the Stuart Foundation. This group has developed joint principles, a report on the first set of meetings known as the *Bridges* report, and a matrix of model projects for forming stronger links between child welfare and AOD treatment agencies.

The child abuse and neglect issue is made even more urgent by recent changes in federal and state legislation which "speed up the clock" in making decisions about whether children who have been removed from their homes will be reunified with their parents. The Adoption and Safe Families Act of 1997 made special reference to younger children, for whom bonding and attachment problems in the first years of life can have profound later consequences. Giving these children permanency - either back in their birth homes or with adoptive parents - is given more emphasis by the new law, which requires earlier hearings and decisions about reunification.

For some of these children, taking a developmental view of their lives means that there can be as many as four different "clocks" running in their lives. The first is the clock just mentioned on termination of parental rights if parents are not making progress in dealing with their problems. The second clock affecting many of these same families is the termination of welfare benefits under welfare reform (in some counties, the welfare clock is a factor in over 90% of the *child welfare* cases). The third clock is the timetable of recovery from addiction, described by some as "one day at a time for the rest of your life." And the final and most important clock is the developmental clock that measures progress being made by younger children during the first five years of life - the rationale for Proposition 10 itself.

In the last two years, five national reports and a California-specific report have addressed the problem of children in the child welfare system affected by their parents' substance abuse. These reports (cited in the literature review on page 18) set out a series of recommendations for actions that would remedy the gaps between child welfare and treatment agencies. A summary of actions taken by California counties in response to these recommendations can be found at http://www.cffutures.com.

In California, on average, children under 6 make up approximately 37% of all children in foster care. Federal data in 1996 placed the comparable national number at 35%. However, in 1995, 55% of all children entering foster care *for the first time* were under 6. A study of nine California counties in the late 1990s found that 6% of all child abuse *reports* were of infants (birth-12 months), 11% were for toddlers (1-2), and 19% were for pre-school-aged children (3-5), for a total of 36% of all reports. As a baseline for comparison with these figures, the 0-5 age group is approximately 33% of all California children and 31% of all children in the U.S. In 1997, the GAO reported that young children are the fastest growing group of children placed in foster care, and that substance abuse played a role in 78% of the cases in which children under 5 years old were placed in foster care.

Another GAO study of California and Illinois suggests that as many as 58,000 children in out-of-home care in California face termination of their parents' rights as a result of the new adoption requirements and the length of time they've been in foster care. This study estimated that 35,000 of those children are from families affected by substance abuse.

Another set of coalitions in the child welfare field are the groups that seek to establish "community partnerships" to enlist neighborhood support in identifying cases that need the

attention of child protective services workers and supporting families who have been reported for child abuse or neglect but evaluated as not severe enough to justify removal of their children. These lower-severity cases have been the focus of such community partnerships in some cities, with the goal of ensuring that community groups are assisting the local CPS agency in preventing further abuse.

Finally, dependency or family courts have a significant role to play in coordinating ATOD-linked services to younger children and their parents or caretakers. Under child welfare law, which has been recently amended by the Adoption and Safe Families Act of 1997, younger children have special standing in the courts when their parents are deemed unable to care for them. As discussed above, the links between child welfare and AOD treatment agencies come into play when substance abuse is affecting parents 'ability to take care of their children. The 'clock "runs faster in the case of younger children in making decisions about reunifying or leaving them with their parents or terminating their parents 'legal rights, based on these younger children's special needs for bonding and attachment with a reliable, permanent caretaker. An increasing number of family courts are adopting "drug court principles, " which use the power of the court to compel parents 'participation in AOD treatment, with reinforcers for their behavior and jail time as a penalty for non-compliance. These drug courts also have the power to compel CPS and AOD treatment agencies to make treatment slots available to parents. Thus courts must be involved as key partners in any effort to address the needs of these children. Some states and counties have focused training efforts on judges and other court personnel, given their general unfamiliarity with the stages of addiction, methods of assessing treatment effectiveness, and the special needs of younger children.

A landmark contribution to our knowledge of the needs of younger children in the child welfare system which is full of useful, California-specific information is *The Tender Years: Toward Developmentally Sensitive Child Welfare Services for Very Young Children*, written by Jill Duerr Berrick and her colleagues at UC Berkeley's School of Social Welfare.

IV. Integrating and Coordinating Funding

Funding for ATOD prevention and treatment services is at least as fragmented as most other funding in a federal system that contains more than 800 different categorical programs. Substance abuse prevention funding is available from both state and federal grant programs under the Center for Substance Abuse Prevention and the Substance Abuse Prevention and Treatment Block grant, which provides California a total of $425 million annually at present. There are six other major funding sources that have been used in other states for ATOD prevention and treatment, but some of these are not used in California at present, as shown in the following table:

Funding source	Used in California	Used in Other States
SAPTBG	X	X
Medicaid	X [limited benefits and eligibility criteria proposed expansion pending]	X
IVE child welfare funding		X
TANF	[CalWORKs set aside funding]	X
Welfare to Work funding	X [available but not widely used]	X
CHIP (child insurance expansion)	Healthy Families [limited benefits]	X
Tobacco settlement funding		X

Taken together, these funding sources for AOD treatment are more readily available for women with children than at any prior time in California's history. Proposition 10 funding could serve as a catalyst for weaving together these funds for women with AOD problems who are seeking to enter treatment but have previously been placed on waiting lists.

New federal funds are anticipated during 2000-2001 for building closer links between child protective services and AOD treatment services to parents in the CPS system; these programs were discussed in a recent federal conference jointly sponsored by the Substance Abuse and Mental Health Administration and the Administration on Children and Families and facilitated by a California-based nonprofit, Children and Family Futures. California county applications for these competitive funds could be more credible if Proposition 10 funds were combined with unused CalWORKs services funding (which are substantial in some counties as of late 1999) and other sources such as welfare incentive funding. Planners should ask county agencies responsible for CalWORKs and the Welfare to Work funds from the federal Department of Labor what percentage they have spent from their allocations for supportive services such as mental health and substance abuse treatment, and seek leveraging opportunities with Proposition 10 funds if these other services funds are still available.

A decision: Funding for services or for information needed to build capacity to deliver services more effectively?

The case for using limited funding for improving the capacity of the system to deliver services is sometimes a hard one to make. The need for funding for direct services is always great. But without the ability to track either programs effectiveness or overall progress in improving the well-being of younger children, the large gaps in information systems sometimes mean that funding is neither well-targeted nor well-evaluated. Although the effect of substance abuse on younger children is a problem that affects both the child welfare system and the drug and alcohol treatment system, as discussed above, neither of these systems can accurately track the births and outcomes of these substance-exposed children. The statewide child welfare information system in particular lacks an

efficient mechanism to track the drug and alcohol involvement of its clients, while the drug and alcohol treatment data system in the state does not even count the children in the families of parents in treatment.

The problem of missing indicators and "missing boxes"

One drawback to an information-based strategy is the poor state of data on younger children and ATOD problems. Three examples may make this point concrete:

- *In its most recent report to the federal government, California's Department of Social Services reported that 1.2% of all foster care cases involved substance abuse— a number believed by no one familiar with this problem. Other states have reported figures as high as 62%.*
- *In county child welfare systems, frequently the total number of CPS cases involving AOD abuse is reported as zero, since this data element is an optional field in filling out data for the reporting system that is mandated by the state.*
- *Most AOD treatment programs do not ask parents enrolled in treatment how many children they have, so the number of children affected by treatment is unknown. State AOD data systems do not ask providers or counties to report this number.*

These data gaps are the basis for the recommendation below regarding the need to consider using Proposition 10 funding to improve information systems. These gaps also require action by state agencies to revise and improve their data collection on the impact of ATOD problems on children.

So the case for better data is an obvious one: If we don't even know how many children are affected, how can we target resources or track progress in using those resources? Investing in better information— in an information-based era— is equipping programs with what they need in order to know whether they are helping their clients.

An example of an expenditure which is both capacity-building and a new service to parents and children is instituting comprehensive assessments of the development of children at birth and regular intervals thereafter. Developmental assessments that begin with birth provide much deeper, richer information than a toxicological screen for drugs, since a developmental screening or full-family assessment looks at a wide range of risk and positive factors, rather than the much narrower question of whether or not a mother used illegal drugs in the last few days. Detecting disabilities early, recognizing a parent's need for mental health or substance abuse treatment, or responding to some other condition which is diagnosed before it becomes severe are all powerful arguments for regular screenings and assessments. As stated in the American Academy of Pediatrics guidelines on responding to the problem of drug-exposed infants,

> A comprehensive medical and psychosocial history that includes specific information regarding maternal drug use needs to be part of every newborn evaluation.[9]

Focusing upon the infant, standardized tests such as the Bayley Scales of Infant Development, the Gesell Developmental Schedules, and the Denver Developmental Screening Test are administered at regular intervals. While routine for most middle-income children, such screening tools may be used far less frequently for lower-income children.

V. Conclusions

Proposition 10 commissions reviewing their options should bear in mind that both short-term expenditures and longer-range investments can help address the problems of younger children affected by ATOD. In the short range, the biggest data gaps need to be filled so that commissions can have a better idea of which children and parents they are targeting. There will be some groups of children and parents who are obvious targets for services - those who are already in the child protective services system and have had alcohol or drug problems diagnosed.

Longer-term priorities could include ensuring that investments in home visiting and other early intervention efforts include adequate emphasis upon ATOD problems, both in identification of ATOD-related effects and in parent education and support. For agencies that have not emphasized continuing prevention efforts aimed at ATOD problems, changes over time will be required to strengthen their capacity to do so. Longer-term investments should also seek to build the capacity to shift resources over time from less effective to more effective programs, and to move from measuring programs' outputs to measuring their outcomes on parents and younger children.

VI. Appendix A: Literature Review and Organizational Contacts

Topic	Books/Articles	Key Organizations	Websites
Drug-exposed births	Chasnoff, I.J. (1989). Drug use in women: Establishing a standard of care. *Annals of the New York Academy of Science*, 562: 208-210.		
California drug-exposed births study	W. Vega et al., Prevalence and Magnitude of Perinatal Substance Exposures in California, *New England Journal of Medicine*, 329:8504 (1993).		
American Academy of Pediatrics guidelines	The American Academy of Pediatrics Policy Statement, Vol. 96, No. 2. August 1995, *Drug-exposed Infants.*		http://www.aap.org/policy/00922.html
	Young, N.K. (1997) Alcohol and Other Drugs: The Scope of the Problem among Pregnant and Parenting Women in California. *The Journal of Psychoactive Drugs*, Vol. 29, No. 1.		
Developmental assessments	Berrick, J. et al. (1998) *The Tender Years*	Zero to Three	http://www.zerotothree.org

Prevention programs		Family Resource Coalition of America	http://www.frca.org http://www.sharingsuccess.org/code/e1/pei_fram.html
Home visiting programs	Packard compilation (see website)	Healthy Families	http://www.futureofchildren.org/hv2/index.htm
Child welfare-treatment agency links	April 1999 Department of Health and Social Services Report to Congress Columbia University Center for Addiction and Substance Abuse Report General Accounting Office report on California and Illinois foster care Children § Defense Fund report Child Welfare League of America report The *Bridges* report: Links between AOD treatment and child welfare agencies in California counties	SAMHSA National Clearinghouse on Child Abuse and Neglect Children and Family Futures	http://aspe.hhs.gov/hsp/subabuse99/subabuse.htm http://www.casacolumbia.org/ http:www.samhsa.gov http://www.calib.com/nccanch/ http://www.childrensdefense.org/safestart_healing.html http://www.cffutures.com

VII. Appendix B: Relevant California Experts by County

County perinatal coalitions and service providers: http://www.adp.cahwnet.gov/PDF/per_dir.pdf

County child abuse coalitions

Department of Alcohol and Drug programs: http://www.adp.cahwnet.gov/

CADPAAC– the statewide association of California drug and alcohol program administrators

University of San Diego Addiction Technology Transfer Center: http://www.attc.ucsd.edu/.

Public Health Institute, UC Berkeley: http://www.ctip.org/textonly/index-home.htm

Child Welfare Research Center, Berkeley http://cssr21.socwel.berkeley.edu/cwrc/cwrcpro.html

Child Advocacy Institute, University of San Diego Law School childrensissues@acusd.edu

California Prevention Coalition: http://www.calpartners.org/

National Abandoned Infants Assistance Resource Center:
http://cssr21.socwel.berkeley.edu/aiarc/index.htm

Family Violence Prevention Fund, San Francisco: http://www.fvpf.org/.

Prevention Online: http://www.health.org/

Children ŝ Advocates Roundtable– 150 statewide child advocacy organizations:
http://www.4children.org/chadvlst.htm

VIII. Appendix C: Options for Use of Proposition 10 Funds for Reducing the Harmful Effects of ATOD Use on Younger Children†

Proposition 10 seeks three basic goals in serving children aged 0-5, by state law:

a. Healthy Children
b. Stronger Families
c. Child Development and School Readiness

Some county commissions have added additional goals to the basic ones, including the establishment of an integrated service delivery system across these three areas. All three of these goals present opportunities for multi-year funding for counties and providers working on closer connections between AOD treatment agencies and child welfare agencies to serve clients who need the services of both agencies. These opportunities include:

1. Healthy Children
   a. Updating 1992 studies that determined the actual prevalence in counties of substance-exposed infants based on the SB 2669 screening protocols
   b. AOD focus in home visiting programs for children identified at-risk at birth
   c. Developmental disabilities screenings for substance-exposed children and follow-up services
   d. Treatment programs for mothers (and fathers) and their younger children
2. Stronger Families
   a. AOD treatment for parents of younger children, including client engagement models and recovery paraprofessionals
   b. Parent education models that include additional/improved AOD content
   c. An assessment of the County's readiness to implement the Adoption and Safe Families Act provisions that affect younger children, including the "faster clock" requirements for decisions about such children and the adequacy of treatment capacity to meet time lines under the law
3. Child Care/School Readiness
   a. Head Start, Early Start, and other models of child development programs that address AOD problems
   b. Respite care for parents in CPS programs
   c. Child care funding for a consortium of providers of AOD services to parents of younger children
4. Integrated services
   a. Community partnerships in addressing CPS families' non-critical needs
   b. Combined treatment plans between AOD and CPS agencies
   c. Improvements in information systems that track clients' outcomes in treatment and parenting across agencies
   d. Installation of software for client treatment and monitoring

† This set of options was developed for a workshop at a statewide conference of AOD agencies and child welfare agencies held at Ontario on May 4-5, 2000. The workshop was sponsored by the Stuart Foundation, Children and Family Futures, and statewide associations of county child welfare and AOD administrators.

IX. References

[1] Derived from Young, NK (1997) "Effects of Alcohol and Other Drugs on Children." *Journal of Psychoactive Drugs*, Vol 29, No.1

[2] *Blending Perspectives and Building Common Ground* (1999), U.S. Department of Health and Human Services. Washington, D.C., p. ix.

[3] Vega, W et al., "Prevalence and Magnitude of Perinatal Substance Exposures in California," *New England Journal of Medicine*, 329:8504 (1993)

[4] Chasnoff IJ, Landress HJ, Barrett ME. (1990), The prevalence of illicit-drug or alcohol use during pregnancy and discrepancies in mandatory reporting in Pinellas County, Florida. *New England Journal of Medicine*, 322:1202-1206

[5] Flores GR and M McGuin, Prenatal Substance Abuse in Sonoma County (1996), The Sonoma County Medical Association

[6] Chasnoff IJ, Landress HJ, Barrett ME

[7] *Healing the Whole Family: A Look at Family Care Programs*, 1998. Children's Defense Fund, Washington, D.C.

[8] St. Pierre RG, Layzer JI, and Barnes HB (1995), Two-Generation Programs: Design, Cost, and Short-Term Effectiveness. *The Future of Children*, Vol. 5 . No. 3.

[9] *Drug Exposed Infants*. The American Academy of Pediatrics Policy Statement (August 1995), Vol. 96, No. 2

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